

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003283	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/13/2013
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00126705 and Complaint IN00126718.</p> <p>Complaint IN00126705 Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00126718 Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 11 & 13, 2013</p> <p>Facility number: 003283 Provider number: N/A AIM number: N/A</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: Residential: 57 Total: 57</p> <p>Census payor type: Medicaid: 29 Other: 28 Total: 57</p> <p>Sample: 6</p> <p>Country Charm Village was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00126705 and Complaint IN00126718.</p> <p>Quality Review 05/14/13 by Lisa McColly</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

WZHY11

If continuation sheet 1 of 1